Cultural inroads in DSM-5

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A lot has been said and written about the relevance of well-conceived cultural concepts in the diagnostic assessment of all kinds of patients, in nosological elaborations and in treatment interventions, particularly with psychiatric patients (1). The resulting gains in prevention and public health impact and enhancement of quality of life indicators have also been broadly discussed. These perspectives have been strengthened in the last two or three decades, notwithstanding the notable progress of neurosciences and basic laboratory research (2). Yet, in terms of concrete accomplishments, all these accurate definitions, powerful and passionate advocacy efforts, and scholarly cogent arguments have moved clinical practice only slightly above the level of byzantine exchanges.

In the diagnostic field, facts such as globalization and diversity, buttressed by massive internal and external migrations across the world, and technological advances reachable by the masses in all countries and continents, have made the need for a comprehensive cultural understanding of patients' lives, their symptoms, family history, beliefs and existential suffering, an almost mandatory requirement. Furthermore, realities such as poverty, inequities, racism, political restlessness, collective stress and disasters shape up clinical pictures, help-seeking modalities and the subsequent provider-patient relationship frames with an unmistakable cultural stamp (3).

That is probably why the American Psychiatric Association, the representative psychiatric organization of the United States, the world's most diverse country, initiated in the late 1960s the work of renewing the Diagnostic and Statistical Manual of Mental Disorders (DSM), hinting first at the need of including cultural items in its third version, and giving them a slightly wider, yet still unfairly insufficient, room in DSM-IV and in its revised text, DSM-IV-TR (4).

WHAT WAS CULTURAL IN DSM-IV?

The spokespeople of these DSM versions attempted to present them as innovative documents that included an outline for a cultural formulation (OCF) and a glossary of 25 "culture-bound syndromes" (CBS), formally admitted for the first time in a classification system. Without denying these features, what was not publicized, perhaps for being too obvious, was the fact that the additions were relegated to Appendix I of DSM-IV, the next-to-last in the thick volume, and that this was just a minimal portion of a substantial piece of scholarship and a set of significant suggestions made, after at least two years of deliberations, by a consulting group of distinguished psychiatrists, ironically appointed by the DSM Task Force leadership itself.

These circumstances, however, explain only in part the limited utilization of and meager research conducted on the DSM-IV cultural components. Very few academic or training centers, mainly in Canada, the U.S. and Europe, faced up to the tasks of exploring the feasibility, usefulness and practical applicability of the OCF or the nosological validity of the CBS (5,6). Soon, criticisms about the ontological and practical unfitness of ethnographic approaches (the five narrative areas of the OCF) in the fluid, time-limited course of diagnostic interviews in different clinical settings, started to appear. The actual impossibility to quantify the information, the limited manualization, the obsolescent definitions of CBS presented in a categorical frame, and the still unclear connections between the clinical data and specific aspects of the pharmacological or psychotherapeutic management of many patients were cited as additional limitations (7).

CULTURAL INROADS IN DSM-5

Strengthening the structure and broadening the scope of a document like DSM and, more specifically, making cultural inroads in a *medical* diagnostic instrument whose main purpose is to provide convincing solidity to a decisive clinical step, requires tenacity and patience, among other ingredients. From the beginning, the DSM-5 Committee made explicit pronouncements about the value of culture in diagnosis, with cross-cultural variations in disorder expression as a point of departure. Yet, it was clear that the mission of the Gender and Cultural Issues Study Group, appointed around 2007-2008, was enormously complex, and that the interests of several of its members differed, at times significantly. The idea that culture implied only race and ethnicity (gender was perhaps a related but still independent concept, judging from the name of the Study Group) seemed to predominate and so, the initial discussions focused mostly on epidemiological aspects of just those topics. It was after about two years of deliberations (early 2010) that a Cultural Issues Work Subgroup was created and charged (with the full support of the DSM-5 Committee leadership) to focus on a more genuine and thorough set of cultural diagnostic features.

The guiding mentality of the Work Subgroup was unequivocal: to ensure a recognizable presence of cultural components in the manual, materialized not only in cogent declarations, "statements of principle" or colorful descriptions but,

most importantly, in norms, guidelines, demonstrations and instruments to be used, actively and effectively, in clinical practice. The work took shape gradually, as the size of the subgroup grew from half a dozen to about twenty members with the addition of a number of international advisors. Available research was examined through a close reassessment of the DSM-IV-TR's contents, literature reviews, assessment of existing data banks and sharing of clinical information about the use of OCF (8).

The input of organizations such as the Society for the Study of Psychiatry and Culture, the Group for the Advancement of Psychiatry, the World Association of Cultural Psychiatry, and the Latin American Group of Transcultural Studies provided a valuable influx of diversity. Phone conversations, periodic conference calls, electronic exchanges, face-to-face meetings in professional and scientific events, and an endless traffic of text drafts and reviews were frequently used communication lines.

These deliberations gradually centered around three areas that, in the end, became the pillars of the cultural composition of the new manual (9), in addition to brief suggestions of cultural aspects for each group of disorders: an introductory text outlining the cultural aspects of DSM-5, the elaboration of what were called "cultural concepts of distress", and the preparation, structuring and field trial testing of the Cultural Formulation Interview (CFI) (6-9).

Introductory text

Definitions of *culture* as a social matrix of the whole human experience and a factor of neurobiological development, *race* as a tenuous but pervasive catalogue of identity including physical and physiognomic characteristics that nourish at times ideologically biased interpretations, and *ethnicity*, based on belonging to a society, people or community with common historical, geographic, linguistic or religious roots, precede comments on how culture influences the diagnostic process. However, details of the main cultural variables and of the weight of culture in a general definition of mental disorders are missing here and in other sections of the manual. Similarly, mentions of culture as a pathogenic/pathoplastic element, a supportive/therapeutic agent, a help-seeking/compliance determinant or, ultimately, a prognostic factor were not included (10).

Cultural concepts of distress

As a result of the re-examination of the DSM-IV's glossary of culture-bound syndromes, three more precise and useful concepts have been included. The "boundedness" feature was drastically challenged as its implication of uniqueness has been weakened by migrations and the subsequent broadening of geo-demographic areas. Concepts of illness previously considered "indigenous" have been incorporated in contemporary descriptions (and vice versa). Instead, distress becomes the common conceptual umbrella for three distinctive items: a) *cultural syndromes*: these are entities that cluster co-occurring symptoms, may or may not be recognized as an illness within the culture, but occur, are relevant in the societies of origin and may be noticed by an outside observer; DSM-5 includes only nine of these conditions, adequately supported by research; b) *cultural idioms of distress*: a relatively new name for an old concept (11), these are linguistic terms, phrases or even colloquial ways of talking about suffering, shared by people from the same culture; they are considered neither mental/emotional illnesses nor diagnostic or nosological categories; while their listing is useful – and includes crying styles, body postures, somatic manifestations, etc. – there is agreement on the need to approach them in a more systematic, empirical way; c) *causal explanations*: a needed remnant of Kleinman's rich "explanatory models" concept (12), these convey deeply ingrained views and beliefs about what the patient and his/her family consider the etiology of the reported symptoms, illness or distress; they can be part of folk classifications of disease used by laypeople or healers but, beyond their formal presentation, they may also entail an anticipation of the patient's trust, faith, hopes and expectations.

Cultural Formulation Interview (CFI)

Considered the most refined product of the Subgroup's work, the CFI is both a revised version of DSM-IV's OCF (with specific changes in the five sections of the latter), and a set of semi-structured questionnaires. In its primary format, it has a total of 16 questions that operationalize cultural definitions of the clinical problem, perceptions of cause, context and support, and treatment factors (including self-coping and help-seeking patterns). Each section and most of the questions have additional probes to clarify or deepen the initial responses. The clinical usefulness of the CFI can be expected in any cross-cultural encounter which is, ultimately, what every diagnostic interview entails.

The CFI was used in field trials conducted in seven centers in North America and five in three other continents. The trials included feedback from patients and clinicians about the instrument, through debriefing meetings conducted by the research team. The tool's feasibility, acceptability and utility measures were quite satisfactory (13). In the end, the Work Subgroup created a total of 12 supplemental modules focused on different areas (levels of functioning, social networks, psychosocial stressors, religion and spirituality, etc.) and population subgroups (such as immigrants, refugees, children and adolescents, the elderly, caregivers, etc.), to be used whenever the clinician or the evaluating center felt the need to gather additional data.

The main recommendation is to conduct the CFI at the beginning of any diagnostic evaluation. In the interview's form, the interviewer is given specific instructions as to

areas to explore and questions to ask. A smooth transition to the rest of the interview is suggested, keeping in mind the depth, detail and duration required by the individual case. The use of a "telescoping" modality, based on the observed interview flow (i.e., overall emphasis on cultural issues vs. particular attention to aspects or details of the inquiry) is also encouraged.

DISCUSSION

Agreeing on the importance of culture and cultural factors in psychiatric diagnosis is not guarantee of its full acceptance or consistent consideration in clinical practice. The multifaceted impact of these factors on availability, accessibility and acceptability of mental health and general medical services still leaves out issues of affordability and accountability (14). Neglecting them may lead to non-contextual, therefore irrelevant, clinical information, diagnostic biases and errors, therapeutic disengagement, insufficient coping strategies or uncertain outcomes. Medical educators also must adopt a basic cultural approach if they want to form professionals comprehensively equipped to deal with psychiatric patients in the contemporary world (15). To take for granted cultural sources is a form of condescension; broadening the inroads made so far can only be successfully accomplished through an adequate instrumentalization of the diagnostic process, the first step in the clinical evaluation of every patient.

There are reasons to assume that the cultural innovations in DSM-5, even though placed for the most part in Section III of the manual, reflect a degree of acceptance and commitment. This does not mean that the product is problem-free. Specific mentions of individual strengths and weaknesses, and of risk and protective factors are missing, in spite of the strong cultural load of such features. Moreover, a variety of obstacles or difficulties in their implementation emerge. The disposition of many clinicians to adopt the philosophy and the pragmatics of the CFI, for instance, remains to be seen. Didactic training and familiarity with the new cultural concepts of distress and their use and application in real life cases imply drastic curricular changes. Proof of the applicability of the new instrument in international, indeed global settings is a tall, yet indispensable order. The issue of time and duration of the transactions on cultural areas during the interview cannot be overlooked, more so if the supplemental modules are considered. Last but not least, the pervasive notion that this is still a USA-inspired (or imposed?) demand requires honest discussions by the many sides involved – the whole world and its medical, psychiatric and public health agencies.

Clearly, extensive research addressing all these topics will be needed. Locally perceived connections between cultural categories may help identify missing patterns of comorbidity and underlying biological substrates of psychopathology. Active search of concomitances with existing entities (of Western facture) needs to continue: depressive and anxious entities, as well as somatization disorders, may yet well lodge some of the remaining cultural syndromes (7,8,13,14). The use of interpreters to address crucial language and communication issues, particularly among immigrant, refugee and young age patients, must also be seriously addressed (16).

Answers to these questions lie in the future. However, it is important to remember that, whether we like it or not, the future is here, now, in this era of Orwellian features. Funding research (preferably multisite), the highest hand in this process, is a clear responsibility of those in positions of power. In the case of the CFI alone, its use in different clinical settings (inpatient, outpatient, consultation/liaison, community and rural services, age-based centers, the newest integrated or behavioral medicine units, etc.) must be tested. And to compare the cultural outreach of DSM-5 with ICD-10's or 11's, as well as to evaluate whether neuroscience-based diagnostic approaches such as the Research Domain Criteria (RDoC) of the U.S.. National Institute of Mental Health (17) could be compatible with a culturally-based clinical thinking, are tasks too crucial for us to afford ignoring them.

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DOI 10.1002/wps.20132